Governor's Discretionary Grants

No Child Left Behind Act of 2001

Title IV, Part A, Subpart 1: Safe and Drug-Free Schools and Communities Act

APPLICANT DEMOGRAPHIC INFORMATION

1. Applicant / Government Entity				ODCP Number: (ODCP use only)
Address:	City:	Cou	nty:	Zip Code:
2. Project Title:	Phone Number:	1		
	3a. Start Date of Program:			
3	3b. End Date of Program:			
5. Program Area (check one):		4. Federal Er	mployer Identification Numb	er (FEIN):
#2006A – Summer 2007 Community Prevention Program #2006B – Community Anti-Drug Coalition				
#2006C – Community Prevention Program #2006D – After-School Prevention Programs Serving Youth in High-Priority	School Communities	6. Total Gov	ernor's Discretionary Grant	funds requested:
#2006E – Out-of-School Youth Prevention Programs	School Communities			
7. Certification. We certify that the project proposed in this applica	tion meets annlicable	requirement	s of the Title IV Part Δ	· SDESCA Governor's
Discretionary Grant Program, that all information is correct, and tha				
7a.Project Director (Name and Title):				
Project Director's Address:	City:		E-Mail Address:	Phone Number:
	Zip Code:			FAX Number:
7b. Financial Officer (Name and Title):				
Financial Officer's Address:	City:		E-Mail Address:	Phone Number:
	Zip Code:			FAX Number:
7c. Authorizing Official (Name and Title):				
Authorizing Official's Address:	City:		E-Mail Address:	Phone Number:
	Zip Code:			FAX Number:

DCH 0866 Revised January 2003

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LEGISLATIVE JURISDICTION

Ct(-)	:1-:	la	:11	
County(s)	in whic	n project	WIII	operate:

Provide the following information for the applicant. If the program will operate in more than one county or legislative district, only list the legislative information for the main office or program headquarters.

	District Number	Name of Elected Official
State House District		
State Senate District Number		
Congressional District Number		

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ASSURANCES AND LICENSING INFORMATION

Inst	ruction	s: If yo	ou are i	n agreement with these two options, please click below:
<u>Prog</u>	ram A	ssuran	<u>ices</u>	
				funded under the Governor's Discretionary Grant convey a clear and consistent message that acts e illegal use of drugs are wrong and harmful.
	Yes, all allocated funds will be used to increase, not supplant, the level of state, local, and other non-federal funds for drug and violence prevention programs and activities. The funds awarded under State Grants Program are used only to supplement the level of State, Local, and other non-Federal funds and not to replace funds that would have been available to conduct activities if SDFSCA funds had not been available			
<u>Lice</u>	nsing I	<u>nform</u>	ation	
			_	rds must meet the licensing requirements administered by the Michigan Department of ally promulgated under P.A. 368 of 1978.
	btain a		ition Li	icense, please access the following website: http://michigan.gov/mdch .
•	Hea Sub	lth Car stance	re Facil Abuse	& Health Profession Licensing lities and Programs Program Licensure Substance Abuse License-Prevention Only
	Yes		No	Do you currently have a Prevention License to conduct a prevention program in Michigan?
				If No, please answer the following questions:
	Yes		No	Have you applied for a State of Michigan Prevention License and currently waiting for the license?

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NONPUBLIC SCHOOL PARTICIPATION FORM

(Not required of Public School Academy Applicants)

☐ Check here if NO	eligible nonpublic
--------------------	--------------------

A. Overview

For Governor's Discretionary Grantees with eligible nonpublic schools, the Legislation requires "meaningful and timely consultation" with private school officials. This must occur during the design and development of the Applicant's program. The decision for participation in this funding by the nonpublic schools should be determined <u>before the application is submitted</u>.

The Applicant must assure that eligible nonpublic schools have been consulted in all phases of the development and design of the project including consideration of: (1) which students will receive benefits, (2) how the students' needs will be identified, (3) what benefits will be provided, and (4) how the project will be evaluated. The Applicant shall maintain continuing administrative control and direction over funds and property that benefit students enrolled in private schools.

B. Requirements

1. If you have eligible Nonpublic Schools in your district, complete the Nonpublic School Participation Form. Send a copy of this form to each of your eligible Nonpublic Schools for them to complete and sign. Submit a signed copy of each form to the ODCP and retain a copy for your program records. Note: if any of your Nonpublic Schools do not return this form, submit a completed copy for them and document on the form the dates and methods of your attempted contacts with them (e.g., phone calls, faxes, e-mails, etc.).

Forms may be submitted to the ODCP via mail, fax, or scan as an attachment to this application.

Mail:

Department of Community Health Office of Drug Control Policy Lewis Cass Building, 5th Floor 320 S. Walnut St Lansing MI 48913

Fax: (517) 335-2121

Attach:

Please attach the forms in the Attachment section in the Application Menu.

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NONPUBLIC SCHOOL PARTICIPATION FORM (cont'd)

2. Describe how you have and will continue to provide meaningful and timely consultation with the appropriate representatives of the students enrolled in nonpublic schools during all phases of the development and design of the

SDFSCA program for nonpublic students and teachers. (Check all that apply.)

	Technical assistance is available as requested by the nonpublic school representatives (required).
	Nonpublic representatives were invited to attend a planning meeting prior to submission of this application (required).
	Ongoing contact is provided through participation on the advisory council (recommended).
	Follow-up phone contact or site visit is planned for each nonpublic participant (recommended).
	Other meaningful consultation. (Please describe.)
3.	Describe how you will assure that programs and services funded by this grant are equitable for nonpublic school participants. Explain any differences in programs and services offered to nonpublic schools.

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PROJECT SUMMARY

Instructions:

Please provide a clear description of your prevention program including the name of your prevention program(s), the population served, i.e. age levels, out of school youth, parents, youth referred by the courts and when during the year will the program be conducted. (Please limit your response to 1/2 page.)

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NEEDS ASSESSMENT

Needs assessment information is collected prior to implementing a prevention program. Collecting and organizing data is instrumental to this process. Data should be collected from multiple sources and analyzed before identifying specific programs or performance measures. Raw data should be kept on file for local, state, or federal audits..

Instructions:

fy the data sources, and provide the year used to complete the needs assessment. d 1 page per item.)	(Check all that apply. Do not
Law enforcement data (e.g. number of youth arrests, types of violations).	Year
Juvenile court data (e.g. number of youth convictions, types of convictions).	Year
Dropout data	Year

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NEEDS ASSESSMENT (cont'd)

Year

Local school data on drugs and violence	Year
Local Department of Human Services	Year
Local Public Health data	Year
Substance Abuse Coordinating Agency data	Year

Search Institute Asset Survey

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NEEDS ASSESSMENT (cont'd)

Community Mental Health data	Year
Local school delinquency and discipline data	Year
Other Name of Data Source:	Year

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PROJECT DESIGN

Instructions: Complete the following items.

1. <u>Evidence-Based Programs:</u> Prevention programs implemented must be based on evidence-based research that supports the proposed program or strategy, and will reduce violence and/or drug use. The purpose of this section is to document which programs will be utilized in attaining a specific outcome goal.

In sections I, II, or III below, please identify at least one evidence-based program you plan to implement.

I) U.S. DEPARTMENT OF EDUCATION

http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf

Aggression Replacement Training
Big Brothers Big Sisters of America
Families And Schools Together (FAST)
Life Skills by Botvins
Project ALERT
Project Towards No Drug Abuse (T.N.D)
Promoting Alternative Thinking Strategies (PATHS)
Second Step: A Violence Curriculum
Reconnecting Youth
Strengthening Families Program: For Parents and Youth 10-14
Students Managing Anger & Resolution Together (SMART) Team

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PROJECT DESIGN (cont'd)

2. **Program Schedule.** Provide program timelines and daily schedules. This description should describe the proposed day-to-day program, and daily program schedule of activities. For example, if your prevention program is planned for after school or on weekends, provide the exact days, hours, and location, as well as the specific services offered each day.

DAYS OF THE WEEK	PROGRAM/ACTIVITIES	LOCATION
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

How	long will your program be conducted?
	1 Month
	6 Months
	9 Months
П	Other

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PROJECT DESIGN (cont'd)

3. <u>Collaboration.</u> Identify two or mor	e partners collaborating with your agency and their function
Agency Name	Function

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MANAGEMENT PLAN AND PROJECT ORGANIZATION - PART I

Instructions: Please complete one page for each staff member listed on the <u>Budget Detail</u> page. If entering multiple staff members, enter information for the first staff member and click **Add**. The first staff member will be saved, and fields on the screen will clear allowing for another staff member to be added. Once the final staff member has been entered, click **Save**. To delete a staff member, use the drop-down menu; navigate to that person and click **Go**. Click **Delete** to remove the staff member from the list.

1. Project Staffing: Complete the following information for each permanent or part-time employee listed on the Budget Detail page.
Name:
Title:
Qualifications: (Please limit your response to 1/4 page.)

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MANAGEMENT PLAN AND PROJECT ORGANIZATION - PART I (cont'd)

Responsibilities: (Please limit your response to 1/4 page.)
D (* E (* 1E * W 1* *1 V 1/C * D (* D (* 1) *)
Prevention Expertise and Experience Working with Youth/Lommunity Programs, (Please limit voil response to 1/4
Prevention Expertise and Experience Working with Youth/Community Programs: (Please limit your response to 1/4 page.)
page.)
page.)
page.)
Prevention Expertise and Experience Working with Youth/Community Programs: (Please limit your response to 1/4 page.)
Prevention Expertise and Experience Working with Youth/Community Programs: (Please limit your response to 1/4 page.)
Prevention Expertise and Experience Working with Youth/Community Programs: (Please limit your response to 1/4 page.)

Number of program hours per week:

FY 2008-2009 Governor's Discretionary Grants

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MANAGEMENT PLAN AND PROJECT ORGANIZATION - PART II

Instructions: Please complete one page for each staff member listed on the <u>Budget Detail</u> page. If entering multiple staff members, enter information for the first staff member and click **Add**. The first staff member will be saved, and fields on the screen will clear allowing for another staff member to be added. Once the final staff member has been entered, click **Save**. To delete a staff member, use the drop-down menu, navigate to that person and click **Go**. Click **Delete** to remove the staff member from the list.

2. <u>Subcontractors:</u> Subcontractors are those individuals hired to provide a particular program-related service. It not been determined by the submission date of the application, you are required to submit the Office of Drug Control Policy for approval prior to subcontracting with that individual	he subo	contractor	
Will you be funding a subcontractor to provide services for your program?		Yes	No
If Yes, please provide the following information: Name:			
Position Title:			
Responsibilities: (Please limit your response to 1/4 page.)			

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MANAGEMENT PLAN AND PROJECT ORGANIZATION - PART II (cont'd)

Prevention Expertise: (Please limit your response to 1/4 page.)
Knowledge and Experience Working with Youth/Community Programs: (Please limit your response to 1/4 page.)
Number of program hours per week:

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COMMUNITY ADVISORY COUNCIL

All GDG grantees must have a Community Advisory Council in place to oversee the program and assist the program in a variety of ways. An Applicant may use the agency's current advisory council, a subcommittee of the advisory council, or establish a new advisory council for this grant.

Instru	uctions: Please check all boxes, and other, if applicable.
	Review and provide comments on the Governor's Discretionary Grant application prior to submission.
	Disseminate information about drug and violence prevention programs conducted within the boundaries of the applicant's geographic area.
	On an ongoing basis, advise the applicant regarding how best to coordinate the applicant's Governor's Discretionary Grant funded activities with other related strategies, programs, and activities in the community and region.
	Review the program evaluation plan and results and make recommendations to improve the applicant's drug and violence prevention program.
	Other council activities (Please describe limiting your response to 1/4 page.)
	ocal advisory council should include, to the extent possible, <u>representatives</u> of various community organizations and nolder groups.

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COMMUNITY ADVISORY COUNCIL (cont'd)

Title	Name	Organization
1. State and local		
government agency		
2. Representative of		
schools served		
3. Parent (parent		
representatives must not		
serve in another role on the		
advisory council)		
,		
4. Student		Grade Level:
5. Teacher and other		Title:
school staff		
6. Private schools		School:
7. Mental health		
professional		
P		
8. Medical professional		
6. Wedicai professionai		
9. Law enforcement (e.g.		
police, judicial system,		
probation officer)		
producin officer)		
10 C		
10. Community-based		
organization		

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COMMUNITY ADVISORY COUNCIL (cont'd)

11. Other group with interest and expertise in drug and/or violence prevention (please describ	11.	Other grou	p with interest ar	ld expertise in dr	ug and/or violence	prevention (please describe
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OUTCOME GOALS & EVALUATION

The Federal Principles of Effectiveness require that programs implemented with SDFSCA funds be designed to prevent or reduce violence and illegal drug use. Performance measures must include goals that relate to reduced violence or drug use.

A minimum of one outcome goal is required for submission of the application. The following buttons will assist you in the development of your goal(s):

- •Click Save, upon completion of the following questions.
- •Click Add, to enter more than one outcome goal.
- •Click Delete, to delete the goal you are viewing.
- •Click Go, to return to a saved goal.
- •Click View PDF, to display your outcome goal statement in the appropriate format.
- •Click Help, in the footer or header, to view an example of a good outcome goal.

1	α	TA T	
1.	(-091		ımber
1.	Ovai	110	шист

	Note: Every outcome goal must have a unique to implement. The goal number should be a wl	number to link the evidence based prevention program(s) you planted number.
2.	What type of attitude or behavior will change	ge? (Check only one box)
	☐ Drug use-behavior ☐ Violence-behavior	
	☐ Drug use-attitude ☐ Violence-attitude	
3.	Who is expected to change? The individuals	selected below are the target population(s) for this specific goal:
	Target Population	Estimated Number to Be Served
	☐ Pre-Kindergarten	
	☐ Elementary Students (K-5)	
	☐ Middle School Students (6-8)	
	☐ High School Students (9-12)	
	School age youth <u>not</u> in school: ☐ Homeless	
	☐ Drop Outs	
	☐ Incarcerated	
	☐ Detention	
	☐ Other	
	☐ Parents or Guardians	

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OUTCOME GOALS & EVALUATION (cont'd)

4.	☐ Other (please specify) What type of change is expected?
Sta	ate whether an increase or decrease will occur and then describe the specific change that will take place.
	Example: Drug use Attitude: increase perceived harm in alcohol use. Example: Drug use Behavior: decrease use of tobacco and alcohol use.
5.	What is the percentage of change you expect of the program participants?
6.	When do you expect the change to occur?
7.	Methods of Measurement: In order to determine whether an increase or decrease has resulted due to the implementation of the program, measurements must be taken prior to program implementation and upon completion of the program. All programs must measure progress in achieving their goals.
Ple	ease check as appropriate:
	Valid and reliable pre/post test survey of target group participants (e.g., Dr. Jim O'Neil Survey)
Na	ame of Instrument:
	Pre/Post test program record review (e.g., student disciplinary records)
Ту	pe of Review:
	Valid and reliable interview protocol (recommended for participants 9 years old and younger)
De	escribe:

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OUTCOME GOALS & EVALUATION (cont'd)

8. Pre-Program Data Collection: (coll	lect prior to program implementation)
Who will collect the data?	When will the data be collected?
Where will the data be collected?	
9. Post-Program Data Collection: (col	llect at conclusion of program)
Who will collect the data?	When will the data be collected?
Where will the data be collected?	
10. Responsibility for Program Evalua	tion (check at least one box)
☐ The goal(s) will be <u>evaluated</u> responsibility and will perform the	by the agency implementing the prevention program. The agency assumes ne evaluation tasks.
	by a subcontracted individual or agency that has not been determined at this submit this information to the Office of Drug Control Policy for approval adividual or agency.)
☐ The goal(s) will be evaluated collection and evaluation.	by a subcontracted individual or agency and assumes responsibility for data

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OUTCOME GOALS & EVALUATION (cont'd)

Subcontractors name:	
Address:	
City:	_
State:	-
Zip Code:	_
Sub-contractors Exportion (Limit w	ocmones to 1/ mags.)
Subcontractors Expertise: (Limit re	esponse to ¼ page.)

11. Evaluation Results

Describe how you plan to use the evaluation results to refine, improve, and strengthen the prevention program(s). Also, describe how the results will be made available to the public and that results can be obtained upon request. (*Please limit your response to 1/4 page.*)

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CONTINUATION FUNDING

Instructions: Please complete the following question.

Are you applying for a continuation award for an existing program funded with the Governor's Discretionary Grant funds?
□ Yes □ No
If Yes , please describe the past and present achievements, data results and effect the program has had on reducing violence and preventing drug use. Provide the statistical data and evaluation results to support these achievements. (<i>Limi your response to 2 pages.</i>)

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BUDGET ITEM SUMMARIES

Instructions : Please describe the following budget items as applicable.				
Please provide an explanation of the <i>Salaries and Wages</i> for the Total Expenditures.				
Please provide an explanation of the <i>Fringe Benefits</i> for the Total Expenditures.				
Please provide an explanation of <i>Travel</i> for the Total Expenditures.				

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BUDGET ITEM SUMMARIES (cont'd)

Please provide an explanation of the Supplies and Materials for the Total Expenditures.						
Please provide an explanation of the <i>Contractual (Subcontracts)</i> for the Total Expenditures.						
Please provide an explanation of the <i>Other Expenses</i> for the Total Expenditures.						
rease provide an explanation of the other Duponous for the rotal Expenditures.						

PROGRAM BUDGET SUMMARY

View at 100% or Larger Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CONTRACTOR NAME			DATE PREPARED	Page	Of		
			BUDGET PERIOD				
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT ▶		AMENDMENT	· #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBI				
EXPENDITURE CATEGORY						TOTAL BUDGET (Use Whole Dollars)	
1. SALARIES & WAGES							
2. FRINGE BENEFITS							
3. TRAVEL							
4. SUPPLIES & MATERIALS							
5. CONTRACTUAL (Subcontracts/S	Subrecipients)						
7. OTHER EXPENSES							
8. TOTAL DIRECT EXPEND	NTUDES						
(Sum of Lines 1-7)	JIIUKES						
9. INDIRECT COSTS:	%						
10. TOTAL EXPENDITURES							
SOURCE OF FUNDS	S						
11. STATE AGREEMENT							
12. LOCAL							
13. FEDERAL							
14. OTHER(S)							
15. FEES & COLLECTIONS							
16. TOTAL FUNDING							
AUTHORITY: P.A. 368 of 1978 COMPLETION: Is Voluntary, but is required as a condition of funding		The Department of Community Health is an equal opportunity employer, services and programs provider.					

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH PROGRAM BUDGET COST DETAIL Page PROGRAM CODE **BUDGET PERIOD** DATE PREPARED to ORIGINAL BUDGET AMENDED BUDGET AMENDMENT NUMBER **POSITIONS TOTAL** 1. SALARY AND WAGES COMMENTS **REQUIRED SALARY TOTAL SALARIES AND WAGES** 2. FRINGE BENEFITS (specify) LIFE INS. **DENTAL INS** COMPOSITE RATE **FICA** UNEMPLOY INS. VISION INS. WORK COMP AMOUNT ____ RETIREMENT HEARING INS. HOSPITAL INS. OTHER **TOTAL FRINGE BENEFITS** 3. TRAVEL (specify if any item exceeds 10% of Total Expenditures) \$ 4. SUPPLIES AND MATERIALS (specify if any item exceeds 10% of Total Expenditures) \$ 5. CONTRACTUAL (SUBCONTRACTS) NAME **ADDRESS AMOUNT** 6. EQUIPMENT (specify) \$ 7. OTHER EXPENSES (specify if any item exceeds 10% of Total Expenditures) 8. TOTAL DIRECT EXPENDITURES (sum of Totals 1-7) 9. INDIRECT COST CALCULATIONS \$ Rate

10. TOTAL EXPENDITURES (sum of lines 8-9)